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No. 05-1382

IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v

PLANNED PARENTHOOD FEDERATION OF AMERICA, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE THOMAS MORE SOCIETY, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

Thomas Brejcha
Attorney at Law
29 S. La Salle Street
Suite 440
Chicago, IL 60603
(312) 782-1680

Paul Benjamin Linton*
Attorney at Law
921 Keystone Avenue
Northbrook, IL 60062
(847) 291-3848

**Counsel of Record*

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INTEREST OF *AMICUS CURIAE*[*]

The Thomas More Society, Inc., is a non-profit, public interest law firm based in Chicago, Illinois. It was founded in 1997 to meet the burgeoning legal needs of the pro-life movement. Incorporated as a 501(c)(3) not-for-profit corporation under the laws of the State of Illinois, the Thomas More Society provides legal advice and assistance to those who face harassment, employment discrimination, unjust treatment, civil litigation or criminal prosecution as a result of their pro-life views or their peaceful protest activities. The Thomas More Society has provided legal services and assistance in a wide range of cases, including in this Court the representation of the named petitioners in *Scheidler v. NOW*, 537 U.S. 393 (2003), and *Scheidler v. NOW*, 125 S. Ct. 2991 (2006).

In addition to the legal representation it provides, the Thomas More Society supports appropriate public policy measures that are intended to protect innocent prenatal human life. Consistent with its core mission and the respect for human life that mission implies, the Thomas More Society respectfully submits this brief in support of petitioner the United States.

INTRODUCTION AND SUMMARY OF ARGUMENT

The issue presented in this case, as in *Gonzales v. Carhart*, No. 05-380, is whether the United States has the constitutional authority to ban an abortion procedure, variously described in the medical literature and trial testimony as "intact dilation and evacuation" (intact D&E) or "dilation and extraction" (D&X), that Congress has characterized as "gruesome and inhumane." Pub. L. No. 108-105, § 2(1), 117 Stat. 1201. In that procedure, a physician

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[*] Letters of consent have been filed with the Clerk. None of the counsel for the parties authored this brief in whole or in part, and no one other than *amicus* or its counsel has contributed money or services to the preparation or submission of this brief.

> deliberately and intentionally vaginally delivers a living, unborn child's body until either the entire baby's head is outside the body of the mother, or any part of the baby's trunk past the navel is outside the body of the mother and only the head remains inside the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child's skull and removing the baby's brains) that the [physician] knows will kill the partially delivered infant, performs this act, and then completes the delivery of the dead infant . . . .

Id.

Based upon this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000), the Ninth Circuit held that the Partial-Birth Abortion Ban Act of 2003 (the Act), 18 U.S.C. § 1531, which prohibits this procedure, except when necessary to save the life of the mother, is unconstitutional because it lacks a health exception and imposes an "undue burden" on women seeking pre-viability, second-trimester abortions. *See Planned Parenthood Federation of America v. Gonzales*, 435 F.3d 1163, 1171-81 (9th Cir. 2006). The court held further that the Act is unconstitutionally vague. *Id.* at 1181-84. For the reasons set forth in the Solicitor General's brief, the Ninth Circuit's principal holding – that the Act is unconstitutional because it lacks a health exception – is erroneous and should be reversed.[1]

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[1] *Amicus* emphasizes one point with respect to the health issue. Even assuming that, for some women, an induction may be contraindicated, that for other women, a dismemberment D&E may not be appropriate, and that for yet still other women, it may not be possible to cause "fetal demise" before beginning an intact D&E, respondents failed to identify any circumstances in which *all three alternatives* to performing an intact D&E on a living fetus would be contraindicated, inappropriate or impossible. Respondents' failure to identify such circumstances is fatal to their argument that an intact D&E performed on a living fetus is ever necessary to preserve the woman's health, in either an absolute or even a relative sense.

Rather than address the court's flawed principal holding, *amicus* addresses the court of appeals' alternative holdings.

1. *Undue Burden.* The court of appeals held that the Act imposes an "undue burden" on women seeking pre-viability, second-trimester abortions in violation of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), because its definition of "partial-birth abortion"[2] includes not only intact D&Es, but also other second-trimester abortion procedures – such as dismemberment D&Es and inductions – which account for almost all abortions performed in the second trimester. *See* 435 F.3d at 1176-81. That holding cannot be reconciled with the language or structure of the Act.

By its plain terms, the Act applies only if a physician "deliberately and intentionally" vaginally delivers a living fetus – not *parts* of a fetus – beyond the anatomical markers set forth in the Act (18 U.S.C. § 1531(b)(1)(A)); only if the physician does so "for the purpose of performing an overt act" that he or she knows will kill the fetus (*id.*); only if the physician then performs such an overt act, other than completion of delivery (*id.* § 1531(b)(1)(B)); and only if the physician does all of this "knowingly," rather than by accident or happenstance (*id.* § 1531(a)). The conduct described in the definition of "partial-birth" abortion," together with the *scienter* requirements of the Act, effectively exclude dismemberment D&Es and inductions.

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[2] The Act prohibits a physician from "knowingly" performing a "partial-birth abortion," 18 U.S.C. § 1531(a), which is defined as "an abortion in which the person performing the abortion – (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of the delivery, that kills the partially delivered living fetus." 18 U.S.C. § 1531(b)(1).

In neither procedure does the physician have the specific intent, *at the outset of the procedure*, to deliver the fetus intact for the purpose of performing an overt act that will kill the fetus after it has been partially delivered. Nor does the Act apply when, during the course of a standard D&E or induction, the physician discovers that he or she must perform an overt act that kills the partially delivered fetus in order to complete delivery.

2. *Vagueness*. The court of appeals held that three terms used in the Act – "partial-birth abortion," "living fetus" and "overt act" – are impermissibly vague. *See* 435 F.3d at 1181-84. That holding is also erroneous. Whether the term "partial-birth abortion" has a recognized meaning, apart from the Act, is of no consequence, because it is clearly and carefully defined in the Act itself. The term "living fetus" means a fetus with a heartbeat, as respondents' expert witnesses recognized. Finally, the term "overt act," in context, refers to an act that the physician knows will kill the fetus after it has been delivered beyond the anatomical markers set forth in the Act, distinct from those acts (*e.g.*, cutting the umbilical cord) that are required to complete delivery. Individually as well as collectively, then, the challenged terms used in the Act "give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972).

3. *Impact of the Act*. In addition to being foreclosed by the text and structure of the Act, the court of appeals' "undue burden" and vagueness holdings are refuted by official abortion reporting statistics from several States whose partial-birth abortion acts were not enjoined prior to this Court's decision in *Stenberg*. Review of these statistics reveals that enactment of such laws did *not* prevent physicians from performing dismemberment D&Es and inductions. This, in turn, suggests that respondents' alleged fear that enforcement of the Partial-Birth Abortion Ban Act would "chill" physicians from performing conventional second-trimester abortion procedures is baseless.

ARGUMENT

I.

THE PARTIAL-BIRTH ABORTION BAN ACT DOES NOT IMPOSE AN UNDUE BURDEN ON WOMEN SEEKING PRE-VIABILITY, SECOND-TRIMESTER ABORTIONS.

In their complaint, respondents alleged that "the term 'partial-birth abortion' . . . is defined so broadly in the Act as to chill physicians from providing the safest and most common methods of abortion used in the second trimester of pregnancy prior to viability," and thus "imposes an 'undue burden' on the right to obtain previability abortions." Supp. Cplt. at 2, ¶ 4. *See also id.* at 3-5, ¶¶ 9-10. Respondents alleged that a "partial birth-abortion," as defined in the Act, "could occur in any D&E abortion, including, but not limited to intact D&E abortions, as well as in any induction abortion," *id.* at 8-9, ¶ 25, which, taken together, "account for more than 95% of pre-viability abortions performed in the second trimester of pregnancy." *Id.* at 9, ¶ 27. "While not all D&E or induction abortions will proceed in a manner that violates the Act, physicians cannot know or predict in advance which abortions will so proceed. Performing any D&E or induction abortion thus places doctors at risk of violating the Act." *Id.* at 9, ¶ 26. "If the Act were to take effect [respondents] would be chilled from providing D&E or inductions abortions because of the reasonable fear of criminal prosecution and civil liability under the Act." *Id.* at 10, ¶ 29. The Act "imposes an undue burden on women seeking second-trimester abortions," *id.*, which violates their right to privacy and liberty guaranteed by the Due Process Clause of the Fifth Amendment." *Id.* at 12, ¶ 39 (Second Claim for Relief).

Respondents' medical experts testified (at trial or in designated portions of discovery depositions that were admitted into evidence) that the Act *would* prevent them from performing intact D&Es and, depending upon the circumstances, *could*

prevent them from performing standard (dismemberment) D&Es, as well.[3] Drs. Broekhuizen, Grunebaum and Hammond testified that the Act would also prevent them from performing at least some inductions.[4] The court of appeals agreed with respondents' "undue burden" claim and, in the alternative, struck down the Act on this ground. *See* 435 F.3d at 1176-81.

The Ninth Circuit's conclusion – and the testimony of respondents' medical experts concerning the purported scope of the Act's prohibitions – rest on a fundamental misunderstanding of the statutory language, however. Properly interpreted, the Act simply does not apply to procedures other than intact D&Es. Physicians who perform standard (dismemberment) D&Es and inductions do not "deliberately and intentionally" deliver the fetal head or trunk outside the mother's body "for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus." 18 U.S.C. §

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[3] *See* Tr. 50, 74-80 (Paul); 199-202 (Sheehan); 281-83, 334 (Drey); 420-22, 425-26 (Doe); 551-52 (Broekhuizen); 656-57 (Creinin); 822-24 (Westhoff); 1787-88 (Chasen); Hammond Dep. 200:7-15. *See also* Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 3-4. Dr. Grunebaum no longer performs second-trimester abortions because he does not believe that the language of the Act is clear and he does not know whether he is covered by the injunctions that have been issued in the cases challenging the Act. *See* Grunebaum Dep. 31:25-32:8; 160:24-161:18; 167:1-21; 223:14-224:3; 236:8-15.

[4] *See* Tr. 551-53 (Broekhuizen); Grunebaum Dep. 224:6-7; Hammond Dep. 327:6-11. Dr. Frederiksen made the same claim in her expert report. *See* Plaintiffs' Exh. 36, at 4. Three other experts who testified for respondents–Drs. Drey, Chasen and Doe–perform induction abortions, as well as D&Es. Dr. Drey and Dr. Chasen, however, expressed no opinion on the impact of the Act on their performance of inductions. *See* Tr. 281-84; 334 (Drey); 1788 (Chasen). Dr. Doe did offer an opinion on the subject, but the district court sustained the Government's objection to his opinion because it was not discussed in his expert report. *See* Tr. 423-25.

1531(b)(1)(A). A standard D&E contemplates dismemberment (through traction at the internal cervical os) and fetal death while the fetus itself is within or almost entirely within the mother's body. *See Stenberg*, 530 U.S. at 924-27. And induction merely involves induced premature delivery of a fetus, which results in the death of the fetus without the need for any overt act, other than completing the delivery. Neither procedure is undertaken with the specific intent, when it begins, of causing partial delivery of a living fetus outside the mother's body for the purpose of performing an overt act that the physician knows will kill the fetus after such partial delivery. Thus, neither procedure falls within the scope of the Act.

Moreover, the circumstances that *could* lead to any purported need to kill a fetus to complete a vaginal delivery *after* a standard (dismemberment) D&E abortion or induction has begun are simply circumstances that *might* occur, but are not *planned* as part of either procedure (as the Act clearly requires). If such circumstances happen to develop during the performance of a standard D&E or induction, or even if they are foreseen, physicians may cause fetal death after the fetus has been partially delivered without violating the Act. This is so because, *at the outset of the procedure*, they did not "deliberately and intentionally" partially vaginally deliver the fetus outside the mother's body (beyond the anatomical markers specified in the Act) "for the purpose of performing an overt act [other than completing delivery]" that they knew would kill the partially delivered fetus. 18 U.S.C. § 1531(b)(1)(A).

Dilation and Evacuation Procedures

Most of respondents' expert witnesses testified that an intact D&E is simply a variation of a standard D&E and not a distinct procedure.[5] Dr. Creinin, however, testified that an

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[5] *See* Tr. 44, 45, 71 (Paul); 458 (Doe); 521 (Broekhuizen); 795, 807 (Westhoff); 1710, 1826 (Chasen); Grunebaum Dep. 66:3-5;

intact D&E (or D&X) *is* a distinct procedure from a D&E (but one which he does not currently perform). Tr. 736-37. But whether an intact D&E is only a variation of a standard D&E or is a separate procedure, it has certain characteristics that distinguish it from a standard D&E in which the fetus is dismembered during the course of the abortion. Those characteristics, along with the *scienter* requirements specified by the Act, provide a principled basis for distinguishing between intact D&Es and dismemberment D&Es – and for prohibiting the former (when performed with the requisite intent) but not the latter.

First, as respondents' experts generally agreed, intact D&E generally requires more dilation of the cervix, usually over the course of several days, to allow the physician to extract the fetus intact (up to the head, in a breech presentation),[6] than is required to remove the fetus in parts with forceps in a

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214:11-16; Frederiksen Dep. 28:23-24. *See also* Tr. 205 (Sheehan) ("I don't differentiate those two procedures"); Hammond Dep. 94:14-15 ("the fact is a D&E is a D&E is a D&E"); *see also id.* at 95:21-96:17.

[6] There is no evidence in the record that any of the respondents' witnesses ever performs an "overt act" to cause the death of the child *after* its head has completely emerged from the mother's body in a D&E. If the fetus presents in a vertex (head first) or transverse (sideways) position, it is usually converted to a breech position. *See* Tr. 405-06 (Doe); 515-16 (Broekhuizen); 667, 669 (Creinin); 827-29 (Westhoff); 1724-25 (Chasen). In Dr. Chasen's study of intact D&Es, in the few instances in which a vertex presentation was not converted to a breech, fetal death was caused *before* the head was completely outside the mother's body. Tr. 1741-42 (Chasen). *See also* Tr. 761-62 (Creinin) (same in his experience); Frederiksen Dep. 49:12-18 (same). The Act would not apply in such cases.

standard D&E.[7] In Dr. Broekhuizen's words, the greater degree of cervical dilation is the "critical difference" between intact D&E and dismemberment D&E. Tr. 544. Second, intact D&E calls for a different use of instruments and technique. Unlike a standard D&E, in which forceps with serrated inside edges are used in a "twisting" or "rotating" motion to grasp and crush tissue to dismember the fetus at the internal cervical os, in an intact D&E physicians use little or no instrumentation in the uterus and apply "gentle traction" in order to bring the fetus through the cervix intact (or largely intact), at which point an overt act is performed that causes death.[8] Third, in a standard D&E, the physician does not generally know at what stage of the procedure the fetus dies,[9] whereas in an intact D&E, he or

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[7] *See* Tr. 55, 57, 71 (Paul); 165-66, 182-83, 193, 206, 241-42 (Sheehan); 281-82 (Drey); 437 (Doe); 507-08, 518-20, 522, 588 (Broekhuizen); 678, 685, 735, 738-39 (Creinin); 835-37 (Westhoff); 1723 (Chasen) ("In cases in which I am able to do an intact – the intact variation of D&E, those patients tend to have more dilation than patients in whom I must resort to forceps"); Frederiksen Dep. 28:24-29:4. Dr. Hammond implied that the dilation required for to remove the fetus intact is greater than that needed simply to pass instruments through the cervix in a disarticulation D&E. *See* Hammond Dep. 72:18-73:1, 103:22-104:9, 136:2-8. *See also* Grunebaum Dep. 72:3-15; 102:22-103:22; 167:22-168:3 (degree of dilation makes a difference in what options are available).

[8] Tr. 70-71 (Paul); 224-25, 229-35 (Sheehan); 435-36 (Doe); 519, 567-71 (Broekhuizen); 666-668, 740 (Creinin); 837 (Westhoff); 1721, 1759 (Chasen); Grunebaum Dep. 83:11-21; 90:17-91:2; 94:1-14; 106:6-113:23 (describing intact D&E); 150:19-151:14 (in an intact D&E "no instrument . . . enters the uterus"); 165:25-166:17; 175:25-176:3; 213:21-214:6.

[9] *See* Tr. 73 (Paul); 187 (Sheehan); 282 (Drey); Grunebaum Dep. 85:5-21; 125:23-126:1. *See also* Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 4 (in a D&E, "I am unaware of when the fetal heart stops beating").

she knows that it is the act of separating the head from the body, crushing the head with forceps or puncturing the base of the head with a sharp instrument and suctioning (or draining) its contents that causes the death of a fetus that was alive at the beginning of the procedure.[10] It is precisely *because* an intact D&E has distinctive characteristics that differentiate it from a standard D&E that respondents' experts were able to describe it in a leading textbook on abortion practice, teach it as a procedure in medical school and study its relative safety.[11]

Respondents' experts testified that, before performing a standard D&E, they cannot usually predict whether the fetus

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[10] *See* Tr. 512 (Broekhuizen); 823 (Westhoff); 1783-84 (Chasen); Grunebaum Dep. 126:2-4; 127:2-4; 230:13-19; Frederiksen Dep. 28:23-29:17. *See also* Plaintiffs' Exh. No. 36 (Frederiksen Exp. Rep.), at 4 (physician knows that the fetus will not survive an overt act compressing its head). Physicians who do not intend to perform an intact D&Es also recognize that these acts cause death. *See* Tr. 73 (Paul); 422 (Doe).

[11] Dr. Paul's standard reference text on abortion, "A Clinician's Guide to Medical and Surgical Abortion," includes a separate section on "intact D&E." Tr. 11-12, 44 (Paul). Both Dr. Westhoff and Dr. Chasen teach the intact variation of D&E at their university medical centers. *See* Tr. 795, 831-32 (Westhoff); 1711-12 (Chasen). Intact D&E is also taught at a number of other universities and medical colleges. *See* Tr. 832 (Westhoff). And Dr. Chasen was able to design and conduct a "retrospective cohort study" of 383 patients (Plaintiffs' Exhibit No. 19) comparing the relative safety of intact D&E, referred to in the study as "intact dilation and extraction," with disarticulation (dismemberment) D&E at 20 weeks or greater gestational age. Tr. 1735-39, 1742. The study differentiated between "disarticulation with forceps" and "intact extraction," in which the fetus was removed intact up to the head or, in a handful of cases, when the fetus had already died, and disarticulation without forceps occurred after the lower extremities and pelvis had been removed. Tr. 1740-41.

will be removed substantially intact or disarticulated.[12] In their experience, however, removal of an intact (or largely intact) fetus is the exception, not the rule.[13] And even in those

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[12] *See* Tr. 71, 121 (Paul); 206-07, 235 (Sheehan); 406-07, 420, 426, 436, 455, 458, 462-63 (Doe); 522 (Broekhuizen); 681, 786 (Creinin).

[13] *See* Tr. 71 (Paul) (5-10% of second-trimester D&Es); 571 (Broekhuizen) (same); 273 (Sheehan) (one out of every fifteen second-trimester D&Es); 432 (Doe) (15% of second-trimester D&Es, of which 80% were partially delivered and 20% were completely delivered without further instrumentation); 681, 731 (Creinin) (once a month, or slightly more than 2% of the 500 abortions he performed in a recent year). Out of 5,000 D&E abortions Dr. Creinin has performed, the fetus has been delivered intact up to the head before becoming lodged at the internal cervical os on only 50 occasions. *See* Tr. 732, 744-47. In Dr. Hammond's experience, it happens only three times a month. *See* Hammond Dep. 113:2-24. Out of the hundreds of D&Es she has performed, Dr. Frederiksen was unable to state whether she has performed even twenty intact D&Es (or intact D&Xs). *See* Frederiksen Dep. 25:5-8; 26:7-9; 31:6-12; 32:3-6. These physicians generally expect that the abortion will proceed as a dismemberment D&E. *See* Tr. 223 (Sheehan) ("The procedure that we use is generally disarticulation and crushing maneuvers to get the fetus small enough to fit through the aperture"), 221-23 ("routine" D&E "usually" involves disarticulation), 235 (disarticulation "is what we generally do"); 435 (Doe) (common characteristic of a D&E is disarticulation); Hammond Dep. 90:21-01:12 (in "most D&Es," the fetus is disarticulated in parts), *id.* at 81:18-21 (in performing a D&E, Dr. Hammond "extract[s] portions of the fetus with *repeated* insertions of the extraction forceps") (emphasis added). In her expert report, Dr. Frederiksen stated that "When performing D&E abortions, . . . at least some degree of dismemberment in often required." Plaintiffs' Exh. 36, at 2. In describing a standard D&E to his patients, Dr. Broekhuizen informs them that he will use suction methods and instruments "to remove the fetus in parts." Tr. 510, 567. Dr. Creinin also informs his patients that the fetus will be removed "in parts." Tr. 739-40.

exceptional cases, respondents' experts, in performing a standard D&E, attempt to complete delivery without causing the death of the fetus by an overt act after the fetus has partially emerged from the mother's body beyond the anatomical markers specified in the Act.[14] It is only if the fetus cannot be completely delivered without further intervention that these physicians perform an overt act that causes the death of the fetus.[15] But that conduct does not bring them within the scope of the Act because it was not their intent, *at the outset of the procedure*, to deliver a living fetus partially outside the mother's body for the purpose of performing an overt act that they know would kill the fetus before completing delivery. Rather, their intent was, in the first instance, to deliver the fetus

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[14] *See* Tr. 60-61, 67-68, 71 (Paul); 193, 241-42 (Sheehan); 405, 432 (Doe); 511-12, 523 (Broekhuizen); 747 (Creinin) (referring to five to ten "surgical transvaginal abortions" performed between the sixteenth and twenty-four weeks of pregnancy in which the fetus was removed intact without Dr. Creinin having to collapse the skull). At or near twenty-four weeks' gestation, however, Dr. Creinin takes steps to avoid the delivery of a live baby, including holding the head of the fetus on the internal side of the cervical os in order to collapse the skull, even if the entire fetus could have passed through the cervix without having its head compressed. *See* Tr. 747-48. Dr. Frederiksen testified that it is "preferable" to remove the fetus intact without compressing the head. Frederiksen Dep. 30:5-14. Dr. Hammond testified that it would be "desirable" in a D&E "to remove the entire fetus intact from inside through the cervix out of the body without disarticulation, decompression or any other maneuver," although, in his experience, that has never been possible with a live fetus. Hammond Dep. 104:10-23. With induction procedures, when fetal demise has not been caused beforehand by an injection of digoxin or potassium chloride, Dr. Hammond never takes steps to kill the fetus during or after the procedure. If the fetus is born alive, he provides appropriate comfort care for the baby. *Id.* 184:4-17.

[15] *See* Tr. 61, 70 (Paul); 193, 206, 235 (Sheehan); 405, 433 (Doe); 512, 523-24 (Broekhuizen); 680-81, 744-46 (Creinin).

vaginally *without* performing an overt act that would cause its death *after* it had been partially delivered.

Intent at the time the procedure begins, then, is key to liability under the Act (along with performance of the conduct described therein). Unlike physicians who perform standard D&Es, Dr. Westhoff and Dr. Chasen, as a routine part of their abortion practice and in their teaching, perform second-trimester D&Es with the express intention, at the outset of the procedure, of delivering an intact fetus beyond the anatomical markers set forth in the statute, for the purpose of performing an overt act that they know will cause the death of the fetus after it has been partially vaginally delivered. *See* Tr. 795, 801-02, 805, 816-17, 823 (Westhoff); 1710-12, 1722 (Chasen).[16] In contrast to the practice of Drs. Paul, Sheehan, Doe, Broekhuizen, Hammond and Frederiksen and, in certain circumstances, Dr. Creinin, in performing standard D&Es (*see* note 14, *supra*), neither Dr. Westhoff nor Dr. Chasen allows a *partially* delivered fetus to be *completely* delivered without causing its death by an overt act. *See* Tr. 817, 823 ("at that point I will perform one or more acts . . . that I know will kill the fetus") (Westhoff); 1783-84 (Chasen) (same).[17]

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[16] As did Dr. Grunebaum, before he stopped performing abortions. *See* Grunebaum Dep. 88:5-91:2; 95:17-96:21; 106:6-113:23.

[17] *See also* Grunebaum Dep. 96:23-97:17 (Dr. Grunebaum has never performed an intact D&E on a live fetus when the entire fetus was delivered "head to toe" without having its brains suctioned out while its head was lodged at the internal cervical os). Along with Dr. Creinin's chilling testimony that "the purpose of my act is to kill the partially-delivered living fetus because that's the objective of the abortion," Tr. 683, this practice raises disturbing questions about the nature of the "abortion liberty." Is it the right not to be pregnant anymore? or the right to a dead baby when a living (if not viable) baby could have been delivered without in any way endangering the

Moreover, again unlike physicians performing standard D&Es, who do *not* take any special steps to ensure that the fetus will be delivered intact,[18] both Dr. Westhoff and Dr. Chasen employ distinctive maneuvers in performing an intact D&E and both provide significantly greater dilation of the cervix than they would in performing a standard D&E at an earlier stage of pregnancy. *See* Tr. 836-40 (Westhoff); 1723 (Chasen).[19] As a result, Dr. Westhoff, succeeds in performing an intact D&E in one-third to one-half of the cases in which she intends to perform the procedure (after the 19th or 20th week of gestation),

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mother's life or health? Both Dr. Broekhuizen (Tr. 610-11) and Dr. Westhoff (Tr. 847-49) testified that when an abortion is indicated because of maternal health conditions, it is never medically necessary to kill the fetus in the process. In *Wynn v. Scott*, 449 F. Supp. 1302 (N.D. Ill. 1978), *appeal dismissed*, 439 U.S. 8 (1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979), the district court held that, when a physician has a choice of procedures, both of equal risk to the woman, the State may, without interfering with the woman's right to terminate her pregnancy, require the physician to use that procedure "which is least likely to kill the fetus." 449 F. Supp. at 1321. The court explained, "*It never could be argued that she has a constitutionally protected right to kill the fetus. She does not.*" *Id.* (emphasis added).

[18] *See* Tr. 435-36 (Doe); 520 (Broekhuizen); 685 (Creinin). *See also* Tr. 205 (Sheehan) (suggesting that whether the fetus emerges intact is a matter of happenstance). Dr. Sheehan has never performed an intact D&E, as it has been described by the American College of Obstetricians & Gynecologists. *See* Tr. 213. Dr. Creinin has performed an intact D&E only three times, *see* Tr. 736, 784, but never with that intent at the beginning of the procedure. *See* Tr. 766 ("I didn't set out to do it, but it happened that way").

[19] *See also* Grunebaum Dep. 58:24-59:6; 72:6-9 (same). Given adequate dilation, Dr. Grunebaum has a choice to do "an extraction D&E or a dismemberment D&E." *Id.* 212:21-213:4.

see Tr. 819, 836,[20] which is a significantly higher percentage than is reflected in the experience of those physicians who do not set out to perform intact D&Es and who do not take any special steps to ensure that the fetus *will* be delivered intact. *See* note 13, *supra* (indicating that the fetus is partially vaginally delivered intact in only one to twelve percent of the second-trimester D&Es that they perform).

In addition to Dr. Westhoff and Dr. Chasen (and Dr. Grunebaum, when he performed abortions), Dr. Broekhuizen, on very rare occasions, has used his "serial dilitation [dilation]" technique as an alternative to "the traditional D&E-type method," in a manner that would violate the Act. Tr. 536. *See also* Tr. 588. With that technique, Dr. Broekhuizen dilates the cervix with laminaria every four to six hours until he has achieved enough dilation to extract the fetus. Tr. 538. At that point, if there is sufficient dilation for only partial, as opposed to total, extraction, he "compress[es] and decompress[es]" the head of the fetus to complete the procedure. Tr. 538. On two of the three occasions in which he intended to use this technique,[21] the fetus was delivered completely intact without Dr. Broekhuizen having to "compress" or "decompress" the fetal

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[20] Dr. Grunebaum reported the same results. *See* Grunebaum Dep. 47:14-20 (one-half to two-thirds of the 100 D&Es he performed in a recent three year period were *not* intact D&Es, implying that one-third to one-half *were* intact D&Es). Dr. Chasen did not quantify how often he succeeds in attempting to perform intact D&Es, perhaps because he performs only three to five abortions per month. *See* Tr. 1710.

[21] One case involved a patient who had scleroderma with pulmonary hypertension and vascular disease; the other involved a patient whose fetus had a lethal anomaly, skeletal dysplasia (a form of dwarfism). *See* Tr. 537, 539. 591-92, 598-600. Dr. Broekhuizen uses his "serial dilitation" technique whenever he intends to deliver the fetus intact to the head. Tr. 588-59.

head. Tr. 538-40. Nevertheless, in choosing this abortion method in these two instances, his *purpose* was to deliver the fetus intact only up to the head, a method he called "intact D&E," or "D&X." Tr. 588-90, 600. On the third occasion, involving a fetus "with a lethal chromosomal anomaly and significant macrocephaly [or "hydrocephaly," an enlarged head caused by excess fluid in the skull, Tr. 603] that clearly was incompatible with survival," Dr. Broekhuizen induced labor with serial dilation of the cervix, delivered the fetus until its head lodged at the internal cervical os, then inserted a thin trocar (a hollow instrument with a sharp edge, *see* Tr. 524) into the base of the skull, drained the fluids and brain tissue, collapsed the skull with forceps and completed the delivery. Tr. 540-42, 602-03, 606. The fetus was alive when its head lodged at the internal os. Tr. 542. Dr. Broekhuizen acknowledged, however, that in certain circumstances excess fluid may be removed with a needle without causing the death of the fetus. *See* Tr. 603-06.[22] In sum, when it is given its proper construction, the Partial-Birth Abortion Ban Act applies only to physicians who intend, *at the beginning of an abortion procedure*, to perform an intact D&E – the Act does *not* apply to physicians who perform dismemberment D&Es.

Induction Procedures

Respondents claimed that physicians who perform induction abortions could be found to have violated the Act, at least in certain circumstances. *See* Supp. Cplt. at 8-11, ¶¶ 25-27, 29, 31. This case, however does not provide the Court with an appropriate vehicle for determining what effect, if any, the

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[22] Dr. Broekhuizen mentioned that on one or two other "rare" occasions, he had patients who were opposed to induction but wanted an intact fetus for autopsy purposes. Tr. 540. He admitted, however, that compression (or decompression) of the head in these circumstances would destroy the brain and preclude the ability to examine the brain for any pathological analysis. *See* Tr. 581-82

Act has with respect to the performance of induction abortions and, if so, whether that effect is constitutional. Planned Parenthood Federation of America does not provide any medical services. *See* Tr. 130-31 (Craig). Planned Parenthood Golden Gate, the other original plaintiff, does not perform inductions at any of their clinics. *See* Tr. 10 (Paul). Neither respondent alleged that it offers induction procedures. *See* Supp. Cplt. at 3-4, ¶¶ 9, 10. Inductions *are* performed in facilities operated by the City and County of San Francisco, the intervening plaintiff, but in describing the impact of the Act on their services, Dr. Drey mentioned only D&Es, not inductions. *See* Tr. 281-84, 334. Four of respondents' expert witnesses – Drs. Broekhuizen, Hammond, Grunebaum and Frederiksen – perform inductions and testified (or stated in their expert reports) that the Act could affect such procedures.[23] None of them, however, is employed by or performs abortions for the respondents.[24] It was improper, therefore, for the lower courts to consider whether the Act could apply to inductions. In any event, their resolution of this issue was erroneous.

In an induction, the fetus is normally delivered completely intact without the necessity of performing an overt act that kills the fetus after it has been delivered past the anatomical markers specified in the Act. It is the rare situation when, in a breech presentation, the head of the fetus lodges at the internal cervical os and cannot be removed without being compressed or having

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[23] *See* Tr. 551-53 (Broekhuizen); Hammond Dep. 327:6-329:11; Grunebaum Dep. 224:6-14; Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 4. Dr. Chasen performs inductions, but offered no opinion on the effect of the Act on inductions. Dr. Doe's opinion was excluded. *See* note 4, *supra*.

[24] Dr. Broekhuizen is the part-time medical director of Planned Parenthood of Wisconsin (which is not a respondent in this case), but he does not perform abortions at any of their facilities. *See* Tr. 486-88 (Broekhuizen).

its contents suctioned,[25] or, in a vertex presentation, the body is trapped by the umbilical cord after the head has passed through the cervix.[26] In other words, surgical intervention to complete an induction is not planned. *See* Grunebaum Dep. 224:9-10 ("You plan not to do [a] D&E"). The absence of a specific intent, at the beginning of the procedure, to perform the acts prohibited by the Act takes the physician's conduct outside the scope of the Act, even in those situations in which he "anticipate[s]" that he may have to complete an induction instrumentally. Tr. 551-52 (Broekhuizen). The mere possibility that the physician may have to complete an induction or, for that matter, a D&E, in a manner that is described in the Act does not satisfy the statutory requirement that the physician perform the proscribed procedure "knowingly," much less that he or she does so "deliberately and intentionally." *See United States v. Bailey*, 444 U.S. 394, 404-05 (1980) (discussing various mental states). The Act does not apply to inductions.[27]

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[25] *See* Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 4 (it is only when "the induction fails" that "delivery must be completed using D&E surgical techniques"). Dr. Frederiksen normally injects potassium chloride into the fetal heart the day before an induction. *See* Frederiksen Dep. 100:6-13; 103:24-104:5; 109:8-16; 112:22-113:8 ("routinely" causes fetal death by intracardiac injection before performing an induction). The Act would not apply to Dr. Frederiksen in such situations, regardless of her intent.

[26] *See* Hammond Dep. 328:18 (not "a common scenario").

[27] Dr. Broekhuizen testified that in a few "fairly rare situations" involving lethal "disfiguring fetal anomalies," he caused fetal death (by decompressing the chest or abdomen) after the child's entire head was outside the mother's body (in procedures that began as inductions). *See* Tr. 552-53. If, at the beginning of those procedures, it was his intent to proceed in this manner, then his conduct would fall within the scope of the Act.

II.

THE ACT IS NOT UNCONSTITUTIONALLY VAGUE.

In their complaint, respondents alleged that "the [Partial-Birth Abortion Ban] Act is so vague that it fails to give physicians fair warning of which abortion procedures are prohibited." Supp. Cplt. at 2, ¶ 4. *See also id.* at 3-5, ¶¶ 9-10. For that reason, respondents contended, the Act "forces physicians to guess – under threat of criminal prosecution and civil liability – whether performing an accepted medical procedure falls within the Act's proscription." *Id.* at 10, ¶ 30. "Moreover," respondents alleged, "because of the Act's vagueness, prosecuting attorneys may differ widely as to what conduct they believe is proscribed by the Act. It thus subjects [respondents] to arbitrary and discriminatory prosecution." *Ibid.* Relying on these allegations, respondents claimed (in their Fourth Claim for Relief) that, "[b]y failing to give adequate notice of the procedures it proscribes, and by encouraging arbitrary enforcement, the Act is impermissibly vague, thereby violating the right of [respondents] and their employees and agents to due process, as guaranteed by the Fifth Amendment." *Id.* at 12, ¶ 43. As previously noted, the Ninth Circuit agreed with respondents' claim, finding that the terms "partial-birth abortion," "living fetus" and "overt act" are impermissibly vague. *See* 435 F.3d at 1181-84. That conclusion, however, is not supported by the law or the facts.

To survive a vagueness challenge, a statute "must give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). But the Constitution does not demand "impossible standards of clarity," *Kolender v. Lawson*, 461 U.S. 352, 361 (1983) (internal quotation marks omitted), nor does it require that statutory language provide "mathematical certainty." *Grayned*, 408 U.S. at 110. Rather, a statute is not vague if it is "clear what the [statute] as a whole prohibits." *Id.*

"*Partial-Birth Abortion*"

Dr. Doe testified that the term "partial-birth abortion" has no "commonly understood meaning." Dr. Hammond agreed, adding that the Act attempts to describe a procedure that does not exist in medical practice. *See* Hammond Dep. 199:18-22.[28] But whether "partial-birth abortion" has a "commonly understood meaning" is irrelevant where, as here, the Act *itself* clearly defines the term. Respondents' expert witnesses stated or implied that the Act *would* apply to a physician who intended to perform (and did perform) an intact D&E.[29] The Act, therefore, has an irreducible core of meaning which respondents clearly understand. Their belief that the Act *could* apply to dismemberment D&Es and inductions, however, is ill-founded and, as explained above, cannot be reconciled with the language and structure of the Act.

"*Living Fetus*"

Respondents' expert medical witnesses agreed that a "living fetus" is a fetus with a heartbeat.[30] "Fetus," in turn, refers to an unborn child that has developed beyond the embryonic stage, which is ten weeks as measured by the first

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[28] Dr. Chasen, however, appeared to understand that the term "partial-birth abortion" refers to an intact D&E. *See* Tr. 1788.

[29] *See* Tr. 77-78, 92-93 (Paul); 205 (Sheehan); 282-83, 334 (Drey); 420, 422 (Doe); 507-08 (referring to "serial dilitation" method), 536-40, 582-83 (describing patients for whom intact procedure was used), 550-51 (impact of Act) (Broekhuizen); 735-37, 786 (Creinin); 795, 822-23, 830-32 (Westhoff); 1787 (Chasen); Hammond Dep. 199:7-201:7; Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 3-4.

[30] *See* Tr. 76 (Paul); 201 (Sheehan); 421 (Doe); 788 (Creinin); 822-23 (Westhoff); Frederiksen Dep. 105:6-11; Grunebaum Dep. 229:22-230:1; Hammond Dep. 186:13-20.

day of the woman's last menstrual period (lmp) or eight weeks post-conception. *See* Tr. 14-15, 76 (Paul); 788 (Creinin); 1710 (Chasen). The term "living fetus" does not refer to a *viable* fetus, *see* Tr. 76 (Paul); 421 (Doe); 787-88 (Creinin), *i.e.*, a fetus which has "a realistic chance of long-term survival outside the uterus." Tr. 14 (Paul). The term "living fetus" is not vague.

"*Overt Act*"

Two of respondents' experts testified, without explanation, that they did not understand what the term "overt act" means. *See* Tr. 78 (Paul); 202 (Sheehan). Numerous federal statutes, however, use the term "overt act" to define crimes,[31] and none has been held to be vague. In criminal law, "an overt act" is "an outward act done in pursuance of the crime and in manifestation of an intent or design, looking toward the accomplishment of the crime." *Chavez v. United States*, 275 F.2d 813, 817 (9th Cir. 1960). Here, "overt act" simply refers to a distinct physical act that kills the fetus after it has been partially vaginally delivered (beyond the anatomical markers set forth in the Act), "other than completion of delivery." 18 U.S.C. § 1531(b)(1)(B). Limited in scope by this language, the Act does not include those acts (*e.g.*, cutting the umbilical cord) that would be required to complete delivery. The language in the Act is not unconstitutionally vague.

III.

OFFICIAL STATE ABORTION REPORTING STATISTICS ALSO REFUTE THE VAGUENESS AND UNDUE BURDEN CHALLENGES TO THE ACT.

As explained above, the Partial-Birth Abortion Ban Act,

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[31] *See, e.g.*, 18 U.S.C. § 1117 ("overt act" in furtherance of conspiracy to commit designated homicides); *id.* § 1201(c) ("overt act" in furtherance of conspiracy to kidnap); *id.* § 2101(a) ("overt act" done to incite riot).

properly understood and interpreted, applies only to intact D&Es (performed with the requisite specific intent), and not to dismemberment D&Es and inductions. Apart from the analysis set forth in Sections I and II, however, there is a practical method for testing respondents' claims (and the Ninth Circuit's holdings) that the Act imposes an "undue burden" on physicians who perform pre-viability, second-trimester abortions, and that the Act is so vague that physicians must guess at its meaning and application.

That method examines official abortion reporting statistics from three of the five States – Indiana, Mississippi, South Carolina, South Dakota and Tennessee – whose partial-birth abortion acts were not challenged prior to this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000),[32] and from one State – Virginia – whose law went into effect during litigation.[33] In considering the significance of these statistics, it must be kept in mind that the statutes in these States were not drafted with the same precision as the federal law at issue in this case.[34]

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[32] The statistics set forth in this brief, along with abortion reporting statistics from South Carolina and Tennessee, are also set forth in the brief *amicus curiae* submitted in *Gonzales v. Carhart*, No. 05-380. In *Carhart*, *amicus* presented the statistics to address an "undue burden" claim. Here, they are presented in abbreviated form to address respondents' "undue burden" and vagueness claims.

[33] Even if these statistics are not legislative facts, they are adjudicative facts of which the Court may take judicial notice. *See* FED. R. EVID. 201, and the authorities cited in the brief *amicus curiae* submitted in *Gonzales v. Carhart*, No. 05-380, at 14 note 9. Documents authenticating the statistics discussed in this brief are included in the appendices.

[34] Indiana, Mississippi and South Dakota defined "partial-birth abortion" to mean an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery. *See* IND. CODE ANN. § 16-18-

Yet, despite the imprecise language of these statutes, physicians were not deterred from performing conventional second-trimester abortion procedures. They understood, in other words, that the partial-birth abortion statutes in these States did *not* prohibit dismemberment D&Es or inductions. And neither does the Partial-Birth Abortion Ban Act of 2003.

Indiana, Mississippi and South Dakota all enacted partial-birth abortion bans that became effective on July 1, 1997. *See* IND. CODE ANN. § 16-18-2-267.5 (West Supp. 2005) (defining offense); § 16-34-2-1(b) (West Supp. 2005) (prohibition); MISS. CODE ANN. § 41-41-71 *et seq.* (1999); S.D. CODIFIED LAWS § 34-23A-27 *et seq.* (Michie Supp. 2003). None of these statutes, prior to *Stenberg*, was construed by any state or federal court.

A comparison of official abortion reporting statistics from these States for the first half of 1997, when none of their statutes was in effect, to statistics for the second half of 1997, when all three were in effect, leaves no doubt that respondents' expressed fears that the federal Act would "chill" physicians from performing dismemberment D&Es and inductions are baseless. That comparison also shows that respondents' professed inability to understand what the Act forbids is more contrived than genuine. Review of these statistics enables this Court "to perform a reality check" on respondents' assertion that they would not be able to perform conventional second-trimester abortion procedures if the Act were allowed to go into effect. *Hope Clinic v. Ryan*, 195 F.3d 857, 870 (7th Cir. 1999) (*en banc*), *vacated and remanded with directions*, 530 U.S. 1271 (2000), *on remand*, 249 F.3d 603 (7th Cir. 2001) (*en banc*).

2-267.5 (West Supp. 2005); MISS. CODE ANN. § 41-41-73(2)(a) (1999); S.D. CODIFIED LAWS § 34-23A-32 (Michie Supp. 2003). Virginia added the phrase, "or a substantial portion thereof," to the words "living fetus." *See* VA. CODE ANN. § 18.2-74.2(D) (Michie Supp. 1999). None of these statutes required that the fetus be delivered beyond an anatomical marker *outside the mother's body*.

Indiana

The Indiana State Department of Health reported that 13,208 abortions were performed in 1997, of which 12,429 were suction curettage, 87 sharp curettage, 159 dilation and evacuation (D&E), and two intra-uterine prostaglandin instillation. *See* Appendix A-2.[35] The statistics reflect that 54.71% of the dilation and evacuation procedures (87 of 159) were performed in the second half of the year (when the Indiana partial-birth abortion act was in effect). As these statistics show, the partial-birth abortion act did not prevent physicians in Indiana from performing dismemberment D&Es.

"These data," the Seventh Circuit noted, "are incompatible with plaintiffs' *a priori* belief that the partial-birth abortion statutes will discourage the performance of the D&E procedure or cause the physician to substitute an inferior procedure." *Hope Clinic*, 195 F.3d at 871. In the eighteen months *after* the Indiana partial-birth abortion statute took effect (July 1, 1997 through December 31, 1998), there were 286 D&Es, while in the eighteen months *before* the statute took effect (January 1, 1996, through June 30, 1997), there were 263 D&Es. *See* Appendix A-2 and INDIANA TERMINATED PREGNANCY REPORT 1996 (Jan. 1998) at 20 (Table 20), INDIANA NATALITY, INDUCED TERMINATION OF PREGNANCY, AND MARRIAGE REPORT[:] STATE, COUNTY, AND CITY DATA 1998 at 84 (Table 18). This certainly does not suggest that physicians in Indiana were deterred or discouraged from performing dismemberment D&Es by the enactment of the partial-birth abortion statute.

Official abortion reporting statistics from other States confirm the Seventh Circuit's sense that "partial-birth abortion statutes need not have [and, in fact, *did* not have] the baleful effect the [respondents] foresee." *Hope Clinic*, 195 F.3d at 817.

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[35] In addition, there were 371 unknown procedures and 160 procedures not otherwise classified.

Mississippi

The Mississippi State Department of Health reported that 4,325 abortions were performed in Mississippi in 1997, of which 2,494 were suction curettage, one sharp curettage, 1,788 dilation and evacuation (D&E), and 23 intra-uterine prostaglandin instillation. *See* MISSISSIPPI VITAL STATISTICS 1997 at 43 (Table F3).[36] A breakdown of the data by procedure and month discloses that 41.94% of the dilation and evacuation procedures (750 of 1,788), and almost two-thirds of the prostaglandin instillation procedures (15 of 23) were performed in the *second* half of the year, during the time that the Mississippi partial-birth abortion act was in effect. *See* Appendix B-2. Although the number of D&Es as a percentage of all abortions declined from 44.07% for the first six months of the year (1,038 of 2,355) to 38.07% for the second six months of the year (750 of 1,970), both the number of D&Es performed in the second half of the year (750) and the number of D&Es as a percentage of all abortions for the second half of 1997 (38.07%) leave little doubt that Mississippi's partial-birth abortion act did not prevent physicians in Mississippi from performing dismemberment D&Es. Nor, given the greater numbers of induction abortions performed in the second half of the year, were Mississippi physicians deterred from performing induction procedures.

In 1998, the first full year after the Mississippi partial-birth abortion act took effect, almost one-third of all abortions performed in Mississippi (1,287 of 3,955) were D&Es. *See* MISSISSIPPI VITAL STATISTICS 1998, Table F3 at 43. This represents a slight decline from 1996, the last full year before the partial-birth abortion act took effect, when approximately 37% of all abortions (1,553 of 4,206) were D&Es. *See* MISSISSIPPI VITAL STATISTICS 1996, Table F3 at 43. Nevertheless, the small number of instillation procedures (32) and procedures not otherwise classified (13), which together account for barely one

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[36] There were 19 procedures not otherwise classified. *Id.*

percent of all abortion procedures performed in 1998, suggests that physicians performing abortions in Mississippi were not deterred from performing dismemberment D&E procedures after the partial-birth abortion act became effective. But perhaps the most significant statistic is that more than 2,000 D&Es were performed in Mississippi in the eighteen months *after* the partial-birth abortion act became effective on July 1, 1997. *See* Appendix B-2 and MISSISSIPPI VITAL STATISTICS 1998 at 43 (Table F3). Thus, there is no evidence that physicians in Mississippi were deterred from performing dismemberment D&Es by the unchallenged partial-birth abortion act.

South Dakota

The South Dakota Department of Health reported that 919 abortions were performed in South Dakota in 1997, of which 702 were suction curettage and 217 were dilation and evacuation (D&E). *See* SOUTH DAKOTA VITAL STATISTICS & HEALTH STATUS 1997 at 67-68 & 77 (Figure 24). A breakdown of the data by procedure and month reveals that 26.92% of the suction curettage procedures (189 of 702) and all but one of the dilation and evacuation procedures (216 of 217) were performed in the *second* half of the year, during which time the South Dakota partial-birth abortion act *was* in effect. *See* Appendix C-2.[37] Obviously, the South Dakota partial-birth abortion act did not prevent physicians from performing dismemberment D&Es. Remarkably, almost three times as many D&Es were performed in the eighteen months *after* the South Dakota partial-birth abortion act took effect (889 procedures) as in the eighteen months *before* the act took effect (307 procedures). *See* Appendices C-2, C-4.

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[37] That all but one of the D&Es were performed in the last four months of the year, when only 15 suction curettage procedures were performed, may have been attributable to the retirement of one abortion provider, who preferred using suction curettage, and his replacement by another, who preferred using D&Es.

Virginia

As the result of a stay of a preliminary injunction, *see Richmond Medical Center for Women v. Gilmore*, 144 F.3d 326 (4th Cir.) (Luttig, J.), the Virginia partial-birth abortion act (*see* VA. CODE ANN. § 18.2-74.2 (Michie Supp. 1999)) went into effect on July 1, 1998. The experience of physicians performing abortions in Virginia after the statute took effect completely belied the district court's statement, at the hearing on the preliminary injunction, that "the Act is written so broadly and vaguely that a prosecutor could interpret the Act to include the procedures these physicians perform such as . . . D&E, as the plaintiffs perform them." *Richmond Medical Center for Women v. Gilmore*, 11 F. Supp. 2d 795, 805 (E.D. Va. 1998). Accordingly, the plaintiffs' professed "fear [of] prosecution and the loss of their medical license to practice if they continue performing abortions in their normal course of practice," *id.*, was shown to be groundless.

The Virginia Department of Health reported that 26,115 abortions were performed in Virginia in 1998, of which 24,920 were suction curettage, 14 sharp curettage, 268 dilation and evacuation (D&E), 11 intra-uterine saline instillation and 98 intra-uterine prostaglandin instillation. *See* Appendix D-2.[38] Of these, 46.26% of the dilation and evacuation procedures (124 of 268) and approximately one-half of the instillation procedures (55 of 109) were performed in the *second* half of the year when the Virginia partial-birth abortion act *was* in effect. Dilation and evacuation procedures accounted for 1.07% of all abortions performed in the first six months (144 of 13,341) and 0.97% of all abortions performed in the last six months (124 of 12,773). Although the number of D&Es declined by 13.88% from the first half of the year to the second half of the year (144 to 124),

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[38] The Department reported three hysterectomies, two hysterotomies, 76 unknown procedures and 723 procedures not otherwise classified. *Id.*

the number of D&Es performed in the second half of the year (124) suggests, as in the case of Mississippi, that the partial-birth abortion act did not prevent physicians in Virginia from performing dismemberment D&Es. Indeed, more D&Es were performed in the last six months of 1998 (124), when the partial-birth abortion act *was* in effect, than in the last six months of 1997 (121), when the law was *not* in effect. *See* Appendices D-2, D-3. So, too, more inductions were performed in the last six months of 1998 (55), when the partial-birth abortion act *was* in effect, than in the last six months of 1997 (30), when the law was *not* in effect. *See* Appendices D-2, D-3.

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To summarize the foregoing statistics, almost 1,200 D&Es were performed in just four States in the first six months *after* their partial-birth abortion acts went into effect.[39] Clearly, the physicians in those States were not deterred from performing dismemberment D&Es. Nor were they deterred from performing inductions. A total of 70 inductions were performed in Mississippi (15) and Virginia (55) in the first six months their partial-birth abortion acts were in effect, compared to 62 in the previous six months. *See* Appendices B-2, D-2. There is no evidence that physicians in these States were in any way confused as to what abortions these laws prohibited.

In evaluating the impact of the unchallenged state partial-birth abortion laws on the incidence of dismemberment D&Es and inductions, the experience of States whose laws were in effect *prior* to *Stenberg* is highly instructive. Equally instructive, however, is the experience of these States *subsequent* to *Stenberg*. *Stenberg* was decided on June 28, 2000. As of that date, none of the foregoing partial-birth abortion statutes was enforceable. Had physicians in those States whose laws had not

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[39] Dilation and evacuation: Indiana (87); Mississippi (750); South Dakota (216); Virginia (124).

been enjoined been deterred from performing dismemberment D&Es and labor inductions before the opinion in *Stenberg* was announced, one would expect a dramatic increase in the numbers of such abortions in the second half of 2000. The official abortion reporting statistics from Indiana, Mississippi and Virginia, however, do not show such an increase.[40]

In Indiana, significantly more D&Es were performed in the *first* half of 2000 (122) than in the *second* half of the year (89). *See* Appendix A-3.[41] In Mississippi, the overwhelming majority of D&Es (58 of 68, or 82.95%) were performed in the *first* half of 2000. *See* Appendix B-3. Although few intrauterine instillation procedures were reported for Mississippi in 2000, the majority of them (9 of 14) were performed in the *first* half of the year. *Id.*[42] And in Virginia, slightly more than one-half of the D&Es (1140 of 2154, or 53.57%) were performed in the *first* half of the year, as well as half (7 of 14) of the intra-uterine instillation procedures. *See* Appendix D-4.[43]

Notwithstanding respondents' claims that the Act imposes an "undue burden" on women seeking pre-viability, second-trimester abortions, and that the Act is impermissibly vague – claims that could never be empirically challenged because of

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[40] In South Dakota, the overwhelming majority of abortions performed in 2000 (840 of 878) were classified as "sharp curettage." *See* Appendix C-6. Thirteen were classified as "medical." Six of the twenty-five D&Es were performed in the first half of the year. *Id.*

[41] The data for Indiana do not separately identify the number of labor induction procedures, if any, that were performed during the year. A total of 62 unknown procedures and 147 procedures not otherwise classified were performed in Indiana during 2000.

[42] In Mississippi, only 21 procedures were not classified. *Id.*

[43] Virginia also reported 79 unknown procedures and 79 procedures not otherwise classified. *Id.*

the preliminary injunction that was entered in this case – the experience in those States whose partial-birth abortion acts *were* allowed to go into effect before *Stenberg* was decided, as well as the experience of those States after *Stenberg*, proves that physicians *did* understand the difference between what those acts did and did not prohibit. They did not prohibit – *and were not understood to prohibit* – dismemberment D&Es and labor inductions. That, in turn, suggests that respondents' expressed fears about being subjected to criminal prosecution (and civil liability) for performing dismemberment D&Es and inductions, and their professed doubts as to what conduct the Act prohibits, are unfounded and unwarranted. The Act applies *only* to a physician who, at the outset of performing an abortion, specifically intends to perform an intact D&E, partially vaginally delivers the fetus beyond the anatomical markers described in the statute for the purpose of performing an "overt act" that he or she knows will kill the fetus, and then performs the overt act that kills the fetus, other than completing delivery.

CONCLUSION

For the foregoing reasons, as well as those set forth in the brief of petitioner the United States, the judgment of the court of appeals should be reversed.

Respectfully submitted,

Thomas Brejcha
Attorney at Law
29 S. La Salle Street
Suite 440
Chicago, IL 60603
(312) 782-1680

Paul Benjamin Linton*
Attorney at Law
921 Keystone Avenue
Northbrook, IL 60062
(847) 291-3848

Counsel of Record

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